# Exhibit 6

[redacted]

# Summary Plan Description

*As set forth in supplemental agreements between Delphi Automotive Systems and the UAW dated September 28, 1999*

UAW

DELPHI
Automotive Systems

Dear Delphi Hourly Employee:

As a UAW represented hourly employee working for Delphi in the United States, the coverage provided to you under the negotiated Delphi-UAW benefit plans is ranked among the finest in American industry.

This booklet, "Your Benefits!", provides you a summary description of these excellent benefit coverages. Each of our benefit areas, Health Care, Life & Disability, Personal Savings, Supplemental Unemployment, Pensions, etc., provides you and your family a high level of security. This booklet contains information and instructions to help you receive the full value of Delphi benefits. We hope you take the time to read this booklet carefully and keep it nearby so it will be available when you need to refer to it in the future.

In the event you should have any questions after reading this material, contact the appropriate administrative activity for the benefit plan in question or your local Union Benefit Representative. Phone numbers for all of the benefits administration activities have been provided on page 3.

Sincerely,

Kevin M. Butler
Vice President, Human Resources
Delphi Automotive Systems Corporation

Richard Shoemaker
Vice President
UAW International Union

## Message to Delphi Employees

The information in this "Your Benefits!" booklet is based upon the benefit plan provisions in effect in January 2000 through termination of the 1999 Delphi-UAW Agreement. This booklet is not a contract. However, it is intended to summarize the ways your Delphi benefit plans can help you and members of your family.

This booklet contains an explanation of your employee benefits based on the documents, policies and negotiated Agreements by which these benefits are provided. If there is any difference between the Plan texts and this booklet, the Plan texts and negotiated Agreements always will govern.

The Company reserves the right to end, suspend or amend plans by action of its Board of Directors, subject to any applicable collective bargaining agreement. Amendments also will be made to comply with applicable statutes and regulations. If changes are made, you will be notified.

The information in this booklet with respect to the Pension Plan applies to employees with seniority on or after October 1, 1999, employees retired with benefits payable commencing after September 14, 1999 and eligible surviving spouses of active employees who died after September 14, 1999. The Life and Disability Benefits Program changes generally are applicable to employees at work on or after October 18, 1999. The effective dates for the Health Care Program are described in the Health Care section of this booklet.

The Delphi-UAW Pension Board of Administration and the Delphi-UAW SUB and GIS Boards of Administration have reviewed and approved the explanatory material related to pensions, supplemental unemployment benefits and guaranteed income stream benefits, respectively. The International Union, UAW, has reviewed and approved the material related to life and disability and health care coverages, the Profit Sharing Plan and the Personal Savings Plan.

# Save These Phone Numbers and Websites

## Health Care

| | | |
|---|---|---|
| ■ Health Care Unit at National Benefit Center | 1-800-537-5865 | www.delphinbc.com |
| • National DME/P&O Network | 1-800-936-9314 | |
| • Mental Health & Substance Abuse | 1-877-786-4008 | |
| • COBRA Continuation Unit | 1-800-537-5865 | |
| • LifeSteps (Wellness & Health Promotion) | 1-800-711-5934 | www.lifesteps.com |
| • Prescription Drug (Merck-Medco) | 1-800-711-3459 | www.merckmedco.com |
| • Traditional Dental (Delta Dental Plan of MI) | 1-800-942-0667 | www.ddpmi.com |
| • Vision (MetLife) | 1-800-638-0166 | |

## Life and Disability

| | | |
|---|---|---|
| ■ Life Insurance or Reporting a Death | 1-800-633-3900 | www.delphinbc.com |
| (Hearing or Speech Impaired) | 1-800-872-8682 | |
| ■ Sickness and Accident Administration | 1-800-734-0346 | www.delphinbc.com |
| (Hearing or Speech Impaired) | 1-800-882-3563 | |
| ■ Extended Disability Benefits | 1-800-734-0346 | www.delphinbc.com |
| (Hearing or Speech Impaired) | 1-800-882-3563 | |

## Savings

| | | |
|---|---|---|
| ■ Personal Savings Plan | 1-877-389-2374 | www.delphi401k.com |
| (Hearing or Speech Impaired) | 1-800-655-0969 | |

## Pensions and Layoff Benefits

| | | |
|---|---|---|
| ■ Pension Administration Center | 1-800-659-2000 | www.pension-administration.com |
| (Hearing or Speech Impaired) | 1-800-659-8811 | |
| ■ Consolidated Income Security Administration (CISA) Center – SUB/GIS | 1-800-852-6000 | www.layoffbenefits.com |

## Vehicle Discounts*

| | | |
|---|---|---|
| ■ DaimlerChrysler Fleet Employee Purchase/Lease Program | 1-888-444-4321 | |
| ■ Ford X-Plan | 1-877-975-2600 | |
| ■ GM Smart Lease Program | 1-800-327-6278 | |
| ■ GMAC Insurance | 1-800-642-6464 | www.micgeneral.com |
| ■ GM New Vehicle Purchase Program | 1-800-835-4646 | |
| ■ Isuzu VIP Purchase and Lease Program | 1-800-995-7372 | |

## Other

| | | |
|---|---|---|
| ■ Wage & Employment Verification Center | 1-800-886-3913 | |
| ■ Legal Services | 1-800-482-5007 | |
| ■ Retiree Servicing Center | 1-800-828-9236 | www.delphinbc.com |

**Program conditions are established at the sole discretion of the manufacturer.*

# How To Find The Information You Want

**Your Delphi Benefit Programs are designed to work together to help you meet many personal and financial needs now and in the future.**

| These plans can help you through various events in your life. Page numbers are referenced for your convenience. | When You Save | If You Have Health Care Expenses | If You Become Disabled | In Case of Layoff or Plant Closing | When You Retire | Social Security Information | In the Event of Death | Surviving Spouse Benefits |
|---|---|---|---|---|---|---|---|---|
| Personal Savings Plan | 6 | 8 | 39 | | 8 | 6 | 8 | 8 |
| Profit Sharing Plan | 12 | | | 11 | 11 | 12 | 11 | |
| Health Care Program | | 13 | 38 | 46 | 61 | 27 | | 68 |
| Disability Benefits | | | 34 | 45 | | 39 | | |
| Supplemental Unemployment Benefits | | | 42 | 40 | | | | |
| Guaranteed Income Stream Benefits | | 49 | 51 | 47 | 50 | 48 | 50 | |
| Pension Plan | | 61 | 57 | 58 | 52 | 60 | 59 | 65 |
| Life Insurance Coverages | | | 37 | 45 | 61 | | 62 | 65 |
| Legal Services Plan | | | 91 | 91 | 91 | | | 91 |

A checklist of important items to remember is on page 101.

# Personal Savings Plan

The purpose of the Personal Savings Plan (PSP) is to allow you to save part of your earnings by investing for retirement through convenient and tax-effective payroll deductions. The Plan also provides a tax-effective way for you to invest your Profit Sharing payments.

## Eligibility

You are eligible to participate in the Plan after attaining seniority. Participation in the Plan is voluntary. Therefore, to begin participation, you are required to enroll in the Plan. You may discontinue participation in the Plan at any time.

## Enrollment

To enroll in the Plan or change your existing enrollment, visit the Delphi Investment Center website at www.delphi401k.com or call toll-free, at 1-877-389-2374.

## How the Plan Works

Subject to IRS contribution limits, the Plan allows you to save on a pre-tax and after-tax basis up to 25% of your eligible weekly pay. You can invest in any of the investment options offered under the Plan. Also, any Profit Sharing payment may be invested in the FSP in accordance with the provisions of the Profit Sharing Plan.

Under existing tax laws, your pre-tax contributions to the Plan are not subject to federal income tax. In most cases, the pre-tax amount you save is not subject to state and local income tax as well. In contrast, after-tax contributions are deducted from your pay after all your applicable income taxes (federal, state and local) have been withheld. Your contributions under this Plan are subject to Social Security tax. Therefore, your future Social Security benefits should not be affected adversely by participating in the PSP.

All assets in your account are vested immediately. That is, these assets cannot be forfeited for any reason. All your assets in the Plan are held by a Trustee. Dividends, and other earnings on amounts invested, are reinvested in your Plan account. However, you may elect to receive your dividends from the Delphi Common Stock Fund in cash. You may also change your investment options and transfer your assets on a daily basis.

## Investment Options

The rate of return you earn on your assets will depend on the specific investment option(s) you select and how long your assets remain in the Plan. All of your savings may be invested through payroll deductions in 10% increments, in any of the Plan's investment options.

All of the investment options in the Plan are organized through a specially designed investment option structure known as Pathways. Within the Pathways structure you can invest in the Delphi Common Stock Fund, Mutual Funds, Promark Funds and Socially Oriented Funds. Based on your investment experience and the amount of time you want to devote, you may select one of the Pathways described below or you can mix options from any of the three Pathways.

The three categories of Pathways, which have been designed to simplify your decision making, are as follows:

- **Pathway One**
  Includes option choices you may want to consider if you are new to investing, unfamiliar with investment concepts, or looking for diversified investment choices which require minimal involvement by you.

- **Pathway Two**
  Includes option choices you may want to consider if you have some experience in investing and asset allocation and you wish to select from a group of style-specific funds.

- **Pathway Three**
  Includes option choices you may want to consider if you are an experienced investor who wishes to build a customized portfolio from a large selection of investment options and you have the time to select and actively monitor your portfolio.

For more detailed information on the funds contained in each Pathway, you may access the Delphi Investment Center website at www.delphi401k.com or reference the *Pathways* magazine which you receive on a quarterly basis through the mail.

You will want to read the PSP Prospectus and the Mutual Fund Prospectuses for more complete details on the various investment options. To obtain this information, you may access the Delphi Investment Center website at www.delphi401k.com or call toll-free 1-877-389-2374.

Once you enroll, your investment choice will remain in effect until you change it.

## Valuation of Your Account

Each of the funds will be valued daily. This is done to determine the current market value of your investments. All dividends and interest are reinvested in the funds and accumulate tax free until distributed.

However, any cash dividends on the Restricted Funds are reinvested in the Promark Income Fund. Restricted Funds are those that do not accept contributions or exchanges into the fund and they are General Motors $1-2/3 Par Value Common Stock Fund, General Motors Class H Common Stock Fund, Raytheon Company Class A Common Stock Fund and the Electronic Data Systems Corporation Common Stock Fund. You have the option of receiving cash dividends from the Delphi Common Stock Fund.

## Account Statements and Tax Information

You will receive a statement of your PSP account every three months or you may access a statement via the Delphi Investment Center website at www.delphi401k.com.

Tax information will be furnished to you from time to time during your participation in the Plan.

## Loans

Once each calendar year, you may borrow from your assets in the Plan. The loan may be for any reason. No credit statement is required.

The minimum amount that may be borrowed is $1,000. The maximum loan, when added to the outstanding balance of other Plan loans, will be the lesser of:

(1) $50,000, less the highest outstanding loan balance in the preceding 12 months; or

(2) one-half of the current market value of your account.

The interest rate payable on a loan is the prime interest rate prevailing as of the last business day of the quarter immediately preceding the date of the loan request. The interest rate will remain fixed for the duration of the loan.

Cash for a loan is obtained by selling assets in your account.

Repayment of a loan is made by equal installments through payroll deduction. The minimum repayment amount is $10 per pay period. The loan duration may be from 12 months to 5 years, as you elect. The duration of a loan may be up to 10 years, if the loan is to purchase, or build, a principal residence for you.

There are no prepayment penalties if you decide to repay the loan earlier than scheduled. Amounts repaid are allocated to your Plan account in the same investment option(s) you elect for your payroll deduction savings.

If you fail to make your required loan payments, your loan will be defaulted. A defaulted loan will result in a deemed distribution to you in the amount equal to the outstanding principle and interest of the loan. Such a distribution will be taxable (in whole or in part) and may result in a 10% additional tax.

## Withdrawals

In accordance with provisions of the Plan, prior to receiving a withdrawal of pre-tax assets, you must withdraw all available after-tax assets. You may withdraw your after-tax assets for any reason at any time; however, you must pay income taxes on a portion of the withdrawal. Also, if you withdraw your after-tax assets or pre-tax assets before age 59-1/2, you may be liable for an additional 10% penalty tax.

In regard to pre-tax assets, you may withdraw these assets from your account, for any reason, after age 59-1/2. Prior to age 59-1/2, you may withdraw only in the event of "hardship" when other financial resources are not available to you. The Plan defines a hardship as:

(1) purchase, or construction, of your principal residence;

(2) payment of expenses to prevent foreclosure on, or eviction from, your principal residence;

(3) payment of tuition for post-secondary education for you or your dependents; or

(4) liability for medical expenses for you or your dependents.

Any withdrawal from the Plan for hardship will be limited to the amount of your pre-tax savings and not the earnings on these savings. You may include in the hardship withdrawal request an amount necessary to pay the taxes and penalties resulting from this withdrawal. In addition, before you may withdraw assets for a hardship, you must take all available asset distributions, withdrawals, and loans under all applicable plans maintained by the Corporation. If you withdraw assets because of a hardship, for a period of 12 months following the withdrawal you will be suspended from (1) accumulating further savings under this Plan and (2) certain other Delphi benefit and compensation plans.

## Distribution of Your Account

In the event of your death prior to retirement, any assets in your account may be delivered to your designated beneficiary.

Commencing April 1, 2001, an enhancement has been made to the PSP that eliminates the requirement that a spousal beneficiary withdraw the deceased participant's assets from the Program. As a result, the surviving spouse will be allowed to maintain the account in the in the PSP.

While the assets remain in the Plan, a surviving spouse may: (1) exchange assets among the various investment options offered under the Program; (2) elect partial distributions; and (3) elect to receive monthly, quarterly, semi-annual, or annual installment payments. A surviving spouse may not make any new contributions or initiate loans from the Plan.

If you are married, your beneficiary must be your spouse, unless your spouse has agreed earlier, in writing witnessed by a Notary Public, to the designation of someone else as your beneficiary. If you are not married, and no beneficiary has been named, all the assets in your account will be distributed to the beneficiary designated to receive the proceeds of your basic life insurance under the Delphi Automotive Systems Life and Disability Benefits Program.

Under the terms of the Plan, if you terminate employment or retire, you may continue to leave all assets credited to your account in the Plan. As

long as you have assets in the Plan, you may (1) exchange assets among the various investment funds, (2) borrow against your assets pursuant to the provisions of the Plan, and (3) elect to withdraw all, or part, of the assets in your account at any time.

In addition, you have the opportunity to receive installment payments each calendar month, calendar quarter, semi-annually, or on an annual basis. These payments must be in whole dollar amounts with $100 established as the monthly minimum. You also have the opportunity to change or discontinue installment payments at any time by calling the Delphi Investment Service Center at 1-877-389-2374.

Also, as a terminated or retired participant, any assets remaining in your account after you attain age 70-1/2 are subject to federal minimum annual distribution requirements. As a result, partial distribution of your account will begin no later than April 1 of the calendar year following the calendar year in which you attain age 70-1/2 and will be made annually thereafter.

If a distribution is generated for you and you did not request a distribution of assets, such assets will be distributed in cash and federal income tax will be withheld.

If you request a distribution of assets, such assets will be distributed as you elect.

## Voting Rights

You will be provided the right to vote all shares of Delphi common stock in your account. You will receive a proxy card from the Plan Trustee at the appropriate time to vote the shares in your account. You may sign and return the card to instruct the Trustee how to vote all the shares in your account.

## Tax Considerations

Delphi is required by law to comply with the terms and conditions of the Internal Revenue Code of 1986, as amended, and regulations thereunder (the "Code"). Under the Code for 2001, the limit on pre-tax contributions is $10,500. Other limits on the amount of your contributions may be required to comply with the Code and regulations. You will be notified if any such limits apply to you.

Remember, when you withdraw after-tax contributions you must pay income taxes on the portion of the withdrawal related to investment earnings. Conversely, when you withdraw pre-tax contributions you must pay income taxes on the entire amount distributed to you.

Federal income tax will be withheld on the taxable portion at a mandatory rate of 20% on all distributions that are not directly rolled over to an Individual Retirement Account (IRA) or another qualified plan. If you receive a distribution of your Plan assets, you will be given the option to elect to have the taxable portion of the distribution to be paid as a direct rollover to an IRA or another qualified plan. The amount directly rolled over will be exempt from the 20% withholding requirement. In contrast, the 20% withholding requirement will apply to a distribution that you receive, and then rollover, to an IRA or another plan.

A 10% additional tax will be imposed on the taxable amount of any Plan distribution made when you are under age 59-1/2. The additional tax does not apply however, to a distribution that is directly rolled over to an IRA or another qualified plan. Moreover, the 10% tax does not apply if you (1) separate from service by retirement under the provisions of the Delphi Pension Plan during or after the calendar year in which you attain age 55, (2) use the money for tax-deductible medical expenses, (3) use the money to satisfy a Qualified Domestic Relations Order, (4) die, (5) become disabled, (6) elect a distribution of "flow through" dividends, or (7) receive a distribution caused by a federal tax levy.

If you are over age 59-1/2 and during one taxable year all the assets in your account are distributed to you upon retirement, Total and Permanent Disability, separation from service, or to your

beneficiary upon your death, the taxable income realized on the lump-sum distribution is equal to the value of the lump-sum distribution less your tax basis in the Plan.

A special rule will apply to a lump-sum distribution paid to you if you were at least age 50 on or before January 1, 1986. Under the special rule, you may make a one-time election at any age to have the lump-sum distribution taxed under the ten-year income averaging provisions of the law in effect before 1987 using 1986 tax rates.

As an alternative, if you are eligible to receive a distribution, you can make a direct rollover of the taxable portion of your Plan assets to an IRA, or another qualified plan.

You should consult your personal tax advisor concerning the best approach for you.

## How Your Money Can Grow

The chart below shows how your PSP savings can grow over a period of years at various assumed growth rates.* It assumes that you save $1,000 a year (regardless of increases in pay) and that you do not borrow or withdraw your assets.

| Assumed Growth Rate % | Amount Saved | | | | | |
|---|---|---|---|---|---|---|
| | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 |
| 6 | $5,800 | $13,500 | $23,900 | $37,800 | $56,400 | $81,200 |
| 8 | $6,100 | $15,000 | $28,100 | $47,400 | $75,800 | $117,400 |
| 10 | $6,400 | $16,700 | $33,200 | $59,900 | $102,800 | $171,900 |
| 12 | $6,700 | $18,500 | $39,300 | $75,900 | $140,500 | $254,300 |
| Years | 5 | 10 | 15 | 20 | 25 | 30 |

* *These growth rates are hypothetical only. There is no assurance that your savings will grow at any assumed rate.*

For example, assuming a 10% growth rate, after 20 years, your $20,000 ($1,000 X 20) savings would be worth $59,900.

# Profit Sharing Plan

The purpose of the Profit Sharing Plan is to provide you with a share in Delphi profits from U.S. operations, commencing with the first dollar of such profits.

## Eligibility

You are immediately eligible to participate in the Plan on your date of hire. In addition to active employees, employees who worked for Delphi during the year but retired, died, or were placed on layoff or leave of absence before the end of the year may receive a share of the Corporation's Profit Sharing distribution.

## How the Plan Works

The formula for the plan provides that a distribution of the "total profit share" is made to you for any year in which Delphi's North American Operations in the United States earn a profit (before-tax).

The amount of the "total profit share" distributed among all eligible employees is the sum of:

(a) 6% of profits between 0% and 1.8% of sales and revenues; plus

(b) 8% of profits between 1.8% and 2.3% of sales and revenues; plus

(c) 10% of profits between 2.3% and 4.6% of sales and revenues; plus

(d) 14% of profits between 4.6% and 6.9% of sales and revenues; plus

(e) 17% of profits which exceed 6.9% of sales and revenues.

Your share of any Profit Sharing distribution is based on your eligible compensated hours, up to a maximum of 1,850 hours per year. Those hours generally include any time for which you receive pay, including your straight-time hours, for such things as:

- Bereavement Pay;
- Call-in Pay;
- Holiday Pay;
- Jury Duty;
- Overtime;
- Short-term Military Duty; and
- Vacation

## The Amount of Your Share

The amount of your share is determined by a simple two-part formula, as follows:

1. First, the Profit Sharing rate is determined.

| The Total Profit Sharing Amount for U.S. Hourly Employees | ÷ | The Total Eligible Compensated Hours for U.S. Hourly Employees | = | The Profit Sharing Rate ($ per hour) |
|---|---|---|---|---|

2. Next, your share is calculated.

| The Profit Sharing Rate | x | Your Eligible Compensated Hours | = | Your Share |
|---|---|---|---|---|

If you flow back to Delphi from General Motors (or to General Motors from Delphi) under the terms of the Delphi-UAW National Agreement, your Delphi Profit Sharing amount will be calculated based upon a maximum of 1,850 eligible compensated hours between the two companies.

For example, if you earned 1,100 eligible compensated hours at GM prior to flowing back to Delphi, your maximum eligible compensated hours at Delphi would be 750 (1,850 – 1,100 = 750). Although you may have worked more hours at Delphi, your Delphi Profit Sharing amount would be based on 750 eligible compensated hours.

## Profit Sharing Choices

You may choose to take your profit share as a cash payment. If you elect cash, you will receive your profit share no later than March 15 of the year after the year in which a profit share is generated.

As an alternative, when your profit share is above the $50.00 minimum payment amount, you may direct the Corporation to place up to 100% of your share, in 1% increments, into the Personal Savings Plan. If you do, your money will be invested in your current PSP investment options. You should refer to the first section of this booklet for information on your Personal Savings Plan investment options and distribution procedures.

If you elect to place your Profit Sharing amount in the Personal Savings Plan, it will be subject to Social Security taxes. But federal income taxes — and in most cases, state and local income taxes — will not apply until you withdraw your money at a later date.

If you choose to save your Profit Sharing amount in the Personal Savings Plan, any taxes (e.g. Social Security Taxes) will be withheld from your next regular paycheck — not from your Profit Sharing amount.

Whatever your Profit Sharing choice, remember that your election will remain continuously in effect, until you change it.

# If You Have Health Care Expenses

The Delphi Automotive Systems Health Care Program for Hourly Employees (the Program or the Delphi Program) provides protection for you and your eligible dependents against a wide range of health care expenses. **While coverages provided under the Program are very broad and comprehensive, the Program does not cover all health care services and expenses under all circumstances.** Therefore, you should seek guidance from your health care carrier if you have questions as to whether or not a particular health care service or expense is covered under the Program.

All coverages will become effective on the first day of the month following the month in which you are actively at work, after acquiring seven months of seniority. Generally, if you are not in active service on the date your health care coverages otherwise would start, your coverages will become effective upon your return to work.

Basic hospital, surgical, medical, prescription drug, hearing aid and mental health and substance abuse coverages are known as "core coverages." These coverages are provided through the "Informed Choice Plan" (ICP). Dental and vision coverages also are provided and are known as "non-core coverages." Once you are eligible for the Informed Choice Plan, you may be offered a choice, among three health care options, to the extent they are in effect and available in your area, as follows:

- the Traditional option;
- the Preferred Provider Organization (PPO) option; or
- the Health Maintenance Organization (HMO) option.

Generally, **newly eligible employees will have only HMOs** as their Informed Choice Plan options. This applies for the **first 24 months** of eligibility **for those hired on/after November 18, 1996** and prior to October 18, 1999, and for the **first 48 months for those hired on/after October 18, 1999.** You will be notified how this applies to you, and what your available options are.

The options are designed to provide quality care on a cost-effective basis. Descriptive materials concerning benefits provided under each option are available through the National Benefit Center. Although coverages may differ slightly under the various options, covered expenses generally include the items detailed below. This is a general description only and the provisions of the Program control your eligibility for coverage and specific benefits. A glossary of terms is provided at the end of the health care section.

## The Traditional Option

Under the Traditional option, Delphi provides for financing of the plan, and selected carriers handle administration and claims processing.

The Traditional option has prior authorization (predetermination) and review procedures to help you and your covered family members avoid unnecessary or prolonged hospitalization. Specifically, the appropriateness of the setting is reviewed as well as the proposed length of stay. If your hospital or physician fails to follow the predetermination process, the reimbursement may be reduced. **You will not be responsible for the amount of the reduction, unless you have agreed to accept responsibility. However, if prior authorization is not given, and you elect to have the services performed, such services will be payable at 80% of reasonable and customary charges after the first $100 of expense for such services.** The reimbursement to providers will be

reduced to reflect any waiver or forgiveness by a provider of the $100 or remaining 20%.

The 80% payment limitation and the requirement that payment be made for the first $100 of covered expenses shall not be applicable to an individual enrollee who has incurred a personal expense of $750 under this provision for such covered services in a calendar year or to the covered members of the enrollee's family, if any, after the enrollee and such members have incurred a total of $1,500 in personal expenses under this provision for such covered services in the same calendar year.

**You should inform your physician or hospital that predetermination can be obtained by calling the toll-free telephone number printed on your health care identification card.**

Predetermination is not required in cases of emergency or maternity hospital admissions. **However, emergency hospital admissions must be reported by your physician or hospital within 24 hours after the admission.** This can be done by calling the toll-free telephone number printed on your health care identification card.

## Hospital Coverage Provides...

**payment of charges for:**

- up to 365 days of covered care in a semiprivate room in a **participating hospital** for general conditions, including maternity care (under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods);
- up to 730 days of medically necessary care (other than custodial care), in an **approved skilled nursing facility** for general conditions;
- most medical needs in a hospital, or approved facility, such as supplies, drugs, dressings, anesthesia, x-rays, laboratory tests, intensive care, and routine nursery care;
- most services in the outpatient department of a hospital, such as treatment of accidental injuries and certain medical emergencies, observation care, IV infusion therapy, surgery, physical therapy (up to 60 treatments per condition per year, which also may be performed in an approved facility other than a hospital), and use of an artificial kidney machine, iron lung or similar equipment;
- up to $250 per day for room, board, and all covered services in a **non-participating, non-psychiatric hospital,** and full coverage for the first five days of emergency admissions;
- up to $35 per condition for covered outpatient services received at a **non-participating, non-psychiatric hospital** (services may be covered at a participating hospital rate in some cases of emergency);
- services provided by **approved home health care programs,** including payment for necessary skilled nursing, home health care aides and infusion therapy (effective July 1, 2001);
- hospice services for terminally ill enrollees when provided through an **approved hospice program**; and
- a case management system to identify — and help avoid — unnecessary or prolonged hospital stays. This system may aid those with catastrophic or severe chronic medical conditions and is available on a voluntary basis.

## Medical and Surgical Coverage Provides...

payment of reasonable and customary charges for medically necessary:

- surgery and anesthesia, including pre- and post-operative care;
- obstetrical delivery, including pre- and post-natal care;
- in-hospital consultation;
- in-hospital medical care by the doctor in charge of the case;
- doctor's medical visits, at the rate of two per week, for up to 730 days in an approved skilled nursing facility for general conditions;
- radiation therapy and chemotherapy for certain types of malignant conditions;
- organ transplants for certain organs, up to $25,000;
- laser surgery which replaces a cutting procedure;
- necessary and appropriate diagnostic x-ray, laboratory and pathology services;
- laboratory testing for one routine PAP smear per calendar year;
- mammography screening in accordance with guidelines established by the American Cancer Society;
- outpatient treatment of accidental injuries and certain medical emergencies and observation care;
- voluntary sterilization;
- up to a combined total of (60) physical, functional occupational and/or speech therapy per condition per calendar year;
- speech therapy for children under six with certain congenital and severe developmental speech disorders;
- effective April 1, 2000, physical therapy when provided by a physician or approved independent physical therapist;
- effective January 1, 2000, treatment for rabies exposure;
- effective January 1, 2000, hepatitis C screenings are covered for at risk or symptomatic enrollees;
- effective January 1, 2000, one annual influenza immunization per enrollee;
- In the case of an enrollee who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, coverage includes:
  - — reconstruction of the breast on which the mastectomy has been performed
  - — surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - — prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.

## Ambulance Coverage Provides...

**payment of reasonable and customary charges for medically necessary transportation to the closest available facility for:**

- transfers by ground ambulance, between hospitals, because the originating hospital lacks necessary treatment facilities, equipment, or staff;
- one-way or round-trip transfer for a hospital inpatient who must be taken to a non-hospital facility for a covered CAT scan, MRI or PET examination (provided the facility meets the Program standards for providing such services), when the services are not available in the hospital to which the patient is admitted or in a closer local hospital;
- effective January 1, 2000, one-way transfer from home or scene of incident in cases of medical emergency or accidental injury to the nearest available facility qualified to treat the patient; and
- effective January 1, 2000, round-trip transfer of a homebound patient from the home to the nearest available facility qualified to treat the patient in the case of a medical emergency or accidental injury, or for treatment at a facility when other means of transportation cannot be used without endangering the patient's life.

**Air and/or boat ambulance services are NOT covered.**

## Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Appliances Coverage Provides...

When a doctor prescribes medical equipment or appliances, the items may be covered by your medical plan — whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when the attending physician prescribes such equipment and the carrier approves it. Durable medical equipment and prosthetic and orthotic appliances should be obtained through the Northwood National DME/P&O Network, which was created to provide high quality, cost-effective care for patients requiring these items and services.

If covered items and services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the carrier. The carrier will then send the payment to you, based on the amount that would have been paid to a network provider. You may be required to pay the amount charged by the non-network provider which is in excess of the network fee schedule.

Additionally, Delphi payments toward the Medicare deductible or coinsurance for those individuals enrolled in the Medicare Program will only be made when services are received from a Network Provider.

**You, your physician, or your provider may contact the Network administrator, Northwood National Provider Network, at 1-800-936-9314 for preauthorization, claims processing, assistance in locating participating providers, and for any other questions or concerns.**

**Failure to use the network will result in costs payable by the enrollee.**

## Durable Medical Equipment (DME)

### What is Covered

- equipment that is approved for reimbursement under the Program and meets Program standards, which include being approved for reimbursement under Medicare Part B and being appropriate for use in the home;
- equipment used in a hospital or skilled nursing facility and rented or purchased from such hospital or facility;
- repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance);
- neuromuscular stimulators;
- positioning transportation chairs as alternatives to traditional wheelchairs for children under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders, or congenital abnormalities;
- external electromagnetic bone growth stimulators, in certain approved cases;
- pressure gradient supports for certain patients; and
- pronged and standard canes (when purchased).

## Prosthetic and Orthotic (P&O) Appliances

### What is Covered

- P&O appliances that are furnished by an accredited facility, are approved for reimbursement under the Program, and meet Program standards, including being approved for reimbursement under Medicare Part B;
- orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace;
- appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital;
- replacement, repair, fitting, and adjustments of the appliance;
- wigs and appropriate related supplies for those enrollees under age 18 years who are suffering hair loss from the side effects of chemotherapy;
  - — for the first purchase of a wig and supplies, coverage will be provided up to $200; and
  - — subsequent purchase, at intervals of not less than 12 months, will be covered up to $125.

## Prescription Drug Coverage Provides...

payment of the prescription charge, less a copayment of $5, for each prescription order or refill for:

- the purchase of drugs which require prescription by a licensed physician under federal law;
- injectable insulin and disposable syringes and needles when dispensed with the insulin; and/or
- disposable syringes and needles consistent with the prescribed supply of a covered anti-neoplastic agent.

Drug quantities are limited to a maximum of a 34-day supply per prescription, except for certain maintenance drugs, which may be dispensed in 100 or 200 unit doses. Disposable syringes and needles are limited to a 1-month supply, when prescribed with a 1-month supply of insulin or, if greater, 100 syringes and needles, when prescribed with a 3-month supply of insulin.

**For Traditional and PPO enrollees** prescription drug coverage is administered through the National Managed Pharmacy Program (NMPP). The NMPP is a national network of participating retail pharmacies dedicated to providing prescription drug services that meet high quality standards. Charges for prescription drugs purchased from a network pharmacy are billed directly to the carrier. You may use any of the pharmacies in the network when purchasing prescription drugs.

If prescription drugs are purchased from a non-network pharmacy, you will be required to pay the full charge. You then should file a claim with your assigned carrier. You will be reimbursed 75% of the reasonable and customary charge, after your copayment has been deducted.

However, if prescription drugs are purchased from a non-network pharmacy due to (1) an emergency or (2) your being away from home, you will be required to pay the full charge, which will be reimbursed at 100% of the reasonable and customary charges, after your copayment has been deducted.

## Mail Order Prescription Drugs

**If you are enrolled in the Traditional or PPO option,** the mail order prescription drug program is an option available to you any time you have a prescription to be filled. This program can be particularly helpful and cost-effective when you require maintenance drugs over an extended period of time, or when you do not need to have a prescription filled immediately. Under the mail order program, you can expect to receive your filled prescription about 2 weeks from the time you mail your prescription. You can obtain up to a 90-day supply per prescription. The copayment is $2 per prescription.

You may request order envelopes by writing or calling:

Merck-Medco Rx Services
P.O. Box 182050
Columbus, Ohio 43272-4404
1-800-711-3459

You may also use the Internet site at:

www.merckmedco.com

Using this site is easier and faster than mailing your prescription requests to Merck-Medco.

## Mental Health and Substance Abuse Treatment Coverages...

**for Traditional and PPO option enrollees** are administered through a managed care program which: (1) has a network of panel providers, and (2) promotes the delivery of care in appropriate settings.

A toll free telephone number is available 24 hours a day. In the event you have any questions regarding your mental health/substance abuse coverages or need services you may call 1-877-786-4008. **Remember, you must use panel providers to receive full benefits.**

This service is provided through an integrated mental health and substance abuse delivery system which includes:

- A national central review organization (CRO) which is designated to: (1) confirm the eligibility of the patient for coverage under the Program; (2) authorize and approve all inpatient and outpatient mental health treatment, certain courses of outpatient substance abuse treatment and outpatient psychological testing; and (3) evaluate panel providers and give feedback to the carrier;

- A network of central diagnostic and referral agencies (CDRs) located in most communities which are responsible for making assessments required under the Program for the development of substance abuse continuing care treatment plans. In addition, they make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment. The CDRs also make referrals to panel providers, provide short-term counseling (up to two visits) and perform aftercare planning and follow-up. In addition, CDRs may provide up to three short-term counseling sessions for employees. The CDR may communicate with Work/Family Representatives about assessment and referral activities related to an employee, where appropriate, and when authorized by the employee;

- A limited nationwide network of inpatient and outpatient mental health and substance abuse professionals which includes psychiatrists, Ph.D. psychologists, masters degreed and licensed psychiatric social workers, clinical nurse specialists, hospitals, partial hospitalization programs, halfway houses, and detoxification facilities.

The combined mental health/substance abuse coverage provides for:

- Up to 35 visits per calendar year for outpatient substance abuse treatment. Outpatient mental health coverage provides up to 35 visits per calendar year, with visits 1-20 paid in full and visits 21-35 paid at 75% of the panel reimbursement level;

- Up to a maximum of 45 days mental health and/or substance abuse inpatient care;

- Up to 90 days of care in an approved partial hospitalization treatment facility for mental health and/or substance abuse care. Each day of inpatient care for mental health and/or substance abuse within the benefit period reduces by two the number of days available for partial hospitalization care. Each two days of partial hospitalization care reduces by one the number of days of inpatient care available for the treatment of mental health and/or substance abuse;

- Up to 90 days in a skilled nursing facility for mental health care. Each day of inpatient care for mental health treatment within the benefit period reduces by two the number of available days for skilled nursing facility care. Each two days of care in a skilled nursing facility reduces by one the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital;

- Up to a lifetime maximum of 90 days of care in a substance abuse halfway house treatment program; and

- Psychological testing, when preauthorized by the CRO and performed by a panel provider.

**If mental health services are rendered due to an emergency, then the provider must contact the CRO to receive authorization within 24 hours.** If outpatient mental health services are rendered by a non-panel physician, then the first visit will be covered. Any additional visits must be authorized by the CRO. **Unauthorized visits to a non-panel physician will be paid at 50% of the amount which would have been paid to a panel provider.** These payments will be made to the enrollee, not the provider. The enrollee is responsible for paying the provider. **Mental health services rendered by non-panel, non-physician providers, (psychologists, social workers, etc.) are not covered under the Program.**

Coverage is not available for treatment of mental disorders which are not amenable to improvement (except that coverage is available to determine that the disorder is not amenable to favorable modification) or for the evaluation and diagnosis of mental deficiency or retardation.

The coverage is structured in such a way that every enrollee will have easy access to the panel of providers. **Therefore, if substance abuse services are rendered by a non-panel provider, those substance abuse services are not covered.**

The focus of the substance abuse treatment coverage is to assist employees (and their dependents) in recovering. Toward this end, if an employee discontinues his/her treatment plan, there will be a warning issued for the first occurrence. For the second occurrence, up to $500 will be recovered from the employee as an overpayment. For a third occurrence, up to $750 will be recovered, and for a fourth or subsequent occurrence, up to $1000 will be recovered. Such overpayments will be recovered from the employee through cash payments or deductions from wages, or deductions from non-pension wage replacement benefits. The Medical Director may waive the overpayment if the employee establishes, to the satisfaction of the Medical Director, that the continuing care treatment plan was discontinued for a satisfactory reason.

## Hearing Aid Coverage Provides...

**benefits for you if you are enrolled in the Traditional or PPO option** and you have been examined by an ear specialist (otologist or otolaryngologist). This examination is to determine if your hearing problem is caused by a condition which may be corrected by use of a hearing aid. **This examination is not a covered service.**

If it is determined that your hearing problem may be corrected by use of a hearing aid, benefits can be provided. Payment will be made at the reasonable and customary charges for the following services, when obtained from a participating provider, once during any period of 36 consecutive months:

- audiometric examination;

- hearing aid evaluation test (up to $115, effective 10/1/00 and subject to change each October); and

- one hearing aid (acquisition cost and dispensing fee). However, only the particular hearing aid prescribed as a result of the hearing aid evaluation test will be covered.

Covered services also include an ear mold, necessary fitting and adjustment of the hearing aid, and a follow-up examination to determine the effectiveness of the hearing aid.

Binaural (one aid for each ear) hearing aids may be covered for children under age 19. There must be a hearing loss in both ears, and the examination by the ear specialist also must reveal that such an aid will correct, or prevent, speech impairment.

## The Preferred Provider Organization (PPO) Option

Under this health care arrangement, selected doctors, hospitals and other health care providers in a geographic area are pooled together to provide services to you and your family. Delphi provides for financing of the plan, and selected carriers handle administration and claims processing.

**When PPO providers are used, the PPO option covers all services included under the Traditional option.** The PPO option also offers some additional coverage, when services are provided by PPO providers. These services include:

- 70% payment for a home or office visit by, or on referral from, a PPO physician;
- a maximum of $100 of a PPO physician's fees for well baby care for children under the age of one;
- effective January 1, 2000, certain screening procedures are covered when prescribed by a physician including; one low density lipoprotein test every 5 years beginning at age 20; an annual fecal occult blood test beginning at age 50; and either one flexible sigmoidoscopy exam or barium enema every five (5) years, or one colonoscopy every ten (10) years beginning at age 50;
- limited immunizations, by a PPO provider:
  - — for children six years of age or younger, against diphtheria, tetanus, pertussis, polio, and influenza type B;
  - — for children age one through age 12, against measles, mumps, varicella and rubella; and
  - — for children from birth through age 18, against hepatitis B, and varicella; and
- a prescription drug copayment of $3 per prescription. Use of the mail order prescription drug program, with a $2 copayment per prescription, also is available to PPO enrollees. Again, prescription drug coverage is administered through the National Managed Pharmacy Program (see page 18).

If you are enrolled in a PPO and you incur charges for covered services because you choose to go to a non-PPO provider, without referral by a PPO provider, you will be responsible for 20% of the lesser of (1) the reasonable and customary charges, or (2) the actual charges incurred. Your payments will continue until your out-of-pocket expenses for such payments reach an annual maximum of $500 per person, or $1,000 per family. The 20% payment will not apply in cases of emergency when you are (1) outside the geographic area of your PPO, or (2) in-area but services are not available from a PPO provider.

## The Health Maintenance Organization (HMO) Option

Health Maintenance Organizations (HMOs) are health care delivery systems or organizations which emphasize preventive health care and early treatment, as well as provide medically necessary care for illness and injury. **The scope and level of benefits provided by an HMO may differ from the Traditional option.** Also, in an HMO you must receive services from HMO providers for the services to be covered. Unlike the PPO option, non-emergency services obtained from providers outside of the HMO panel are not covered at all unless the primary care physician makes the referral or the HMO preauthorizes treatment.

HMOs have monitoring systems to assess quality of care, necessity of treatment, and appropriateness of inpatient hospital stays. The coverage varies among individual HMOs, but all HMOs include certain preventive and routine care services such as physical exams, office visits and immunizations. Generally, such care is provided at lower or no cost to you.

HMOs also provide for prescription drugs, mental health, substance abuse and other coverages. **Since coverage of services may vary from the Traditional option and between HMOs themselves, it is important to review HMO materials carefully to become familiar with the scope and level of benefits that are available through a particular HMO.**

HMOs are offered based on your address of record. To obtain information regarding the HMOs available to you, please contact the National Benefit Center. Additional literature can be obtained by contacting an HMO and requesting the membership handbook that describes its benefits and the provider directory which lists the doctors, hospitals, laboratories and pharmacies that participate in that HMO.

Delphi pays the HMO premiums and each HMO handles administration and claims processing.

## Dental Coverage Provides...

benefits up to an annual maximum of $1,500 per person, for other than orthodontics (teeth straightening) during any calendar year, (January 1 through December 31) beginning in 2000. The annual maximum will be increased to $1,600 per person effective January 1, 2003.

The lifetime orthodontics maximum is $1,700 per person as of January 1, 2000 and will be increased to $1,800 effective January 1, 2003 for any individual whose course of treatment begins before age 19. Coverage is not available for treatment begun after attainment of age 19.

Traditional dental coverage for UAW-represented employees is administered through Delta Dental Plan of Michigan (Delta Dental). Benefits are based on the reasonable and customary charges of participating dentists. Benefits for services performed by a non-participating dentist are based on an established fee for services performed. These fees may be lower than the fees payable to participating dentists.

Furthermore, Delta Dental also has developed a network of "preferred" dentists, available in most states, who have agreed to accept reimbursement based on a Dental fee schedule instead of reasonable and customary charges. Enrollees who receive covered services from "preferred" dentists are eligible for enhanced benefit levels. There is no special enrollment required for enrollees to utilize the preferred provider network. These enhanced benefits will be paid anytime an enrollee receives covered services from a preferred provider. Information about "participating" and "preferred" providers is available by calling Delta Dental at 1-800-942-0667.

**If a course of treatment is expected to involve dental expenses amounting to $200 or more, your dentist should file a description of the procedures to be performed and an estimate of the charges with Delta Dental Plan of Michigan prior to the commencement of treatment.** Delta Dental will notify the dentist of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results.

Before treatment begins, you should discuss with your dentist the treatment plan, the fee, and the estimated dollar amount of benefits.

### Benefits are payable at 100% of the reasonable and customary charge for:

- oral examinations and prophylaxis (cleaning of teeth) but not more than twice in a calendar year (three cleanings per calendar year if you have a documented history of periodontal disease or four cleanings per calendar year for two full calendar years following periodontal surgery);
- topical application of fluoride for persons under age 20;
- space maintainers that replace prematurely lost teeth for persons under age 19; and
- emergency treatment for temporary relief of pain.

**Benefits are payable at 90% of the reasonable and customary charge for:**

- dental x-rays, including full mouth x-rays (but not more than once in any period of five consecutive calendar years), and bitewing x-rays (but not more than once in a calendar year);
- extractions and oral surgery;
- amalgam, silicate, acrylic synthetic porcelain and composite fillings;
- general anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- endodontic (nerve and pulp) and periodontal (gum) treatment;
- injection of antibiotic drugs by the attending dentist;
- repair of crowns, bridgework or dentures; and relining or rebasing of dentures more than six months after installation, but not more than one relining or rebasing in any period of three consecutive calendar years;
- inlays, onlays, gold fillings or crowns, but only when the tooth cannot be restored with an amalgam or other filling; and
- cosmetic bonding of 8 front teeth when certain conditions exist for children 8 - 19 years of age, but not more than once in any period of three consecutive calendar years.

The remaining 10% of the reasonable and customary charge is a copayment payable by you.

**Benefits are payable at 50% of the reasonable and customary charge for:**

- initial installation of fixed bridgework;
- initial installation of removable dentures, including any adjustments during the six-month period following installation;
- replacement of an existing denture or fixed bridgework, but only when:
  - (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,
  - (b) the existing denture or bridgework cannot be made serviceable and, if it was installed under this coverage, at least five years have elapsed prior to the replacement; or,
  - (c) the existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture; and
- orthodontic (teeth straightening) procedures and treatment (including related oral examinations) for any person whose course of treatment begins before age 19 (subject to a maximum lifetime payment of $1,700, or $1,800 on or after January 1, 2003). Coverage is not available for treatment begun after attainment of age 19.

The remaining 50% of the reasonable and customary charge is a copayment payable by you.

### Accidental Dental Injury

Additional coverage is available for the repair of accidental dental injury to sound natural teeth due to sudden unexpected impact from outside the mouth. If applicable in a given case, the copayments referenced above will apply (depending on the nature of the service), but benefit payments will not count against annual or lifetime maximums.

### Alternative Dental Plans

are available in some areas. The benefits provided by such plans may be different from the benefits provided under the traditional dental coverage. When enrolled in alternative dental plans, benefits may be reduced or not payable when services are obtained from non-participating dentists.

## Vision Coverage...

is administered by MetLife. Delphi's vision coverage provides assistance toward the cost of routine eye exams, lenses, and frames through a national network of participating providers, which includes ophthalmologists, optometrists, and optical facilities.

### What Is Covered

Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination (by an optometrist or an ophthalmologist) per calendar year including refraction, case history, coordinating measurements, and tests;
- Prescription of glasses where indicated;
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist;
- Materials and professional services connected with the order, preparation, fitting of frames and lenses, and initial adjusting of:
  - —Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year;
  - —Number 1 or 2 tint for lenses;
  - —Contact lenses in lieu of regular lenses:
    - Following cataract surgery;
    - When visual acuity cannot be corrected to 20/70 in the better eye;
    - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature; or
    - Up to $75 when prescribed for any other reason than those listed above;
  - —Frames once during two consecutive calendar years.

Note: Usually, the first pair of lenses, either regular or contact, following cataract surgery are covered under the medical plan.

### What Is Not Covered

Services not covered under vision provisions include, but are not necessarily limited to, the following:

- Any lenses that do not require a prescription;
- Medical or surgical treatment of the eye;
- Drugs or any other medication;
- Procedures determined by the carrier to be special or unusual (e.g., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you; and
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.

## Vision Network

The national vision network is made up of vision providers who have agreed to accept reimbursement based on a regional fee schedule, to meet certain contractual standards for quality, and to provide a selection of frames available to enrollees at no cost.

Going to a participating network provider will reduce your out of pocket expenses. First of all, you will have no copayments or out of pocket expense for covered vision services such as a routine vision exam, regular size lenses, certain designated frames that cost less than $55, or medically necessary contacts. Secondly, if you choose to upgrade your frame selection by choosing a more expensive frame, the retail price of the frame will be discounted. Finally, there are many popular non-covered lens features whose prices are limited or "capped" under the participating provider agreement.

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from the carrier.

**A list of participating providers within 25 miles of your residence may be received by calling 1-800-638-0166.**

## Out of Network

Generally, if you choose to receive covered vision services from a non-participating provider you will have to pay the provider and file your own claim with the carrier. The carrier will reimburse you directly based on the regional fee schedule. There is one exception. Your reimbursement for vision exams provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the carrier minus a $7 copay.

## Out of Area

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider then your reimbursement will be based on reasonable and customary charges as determined by the carrier minus a $7 copayment for exams and a $10 combined copayment for lenses and frames.

## Summary

The chart shown below summarizes the benefit frequency and the level of reimbursement for covered vision services when received In Network, Out of Network, or Out of Area.

| Benefit | Frequency | Network Provider | Out Of Network | Out Of Area* |
|---|---|---|---|---|
| VISION EXAM | Once every calendar year | Covered in full | | |
| Optometrist | | | Enrollee reimbursed based on regional fee schedule | Enrollee reimbursed based on R&C** minus $7 copay |
| Ophthalmologist | | | Enrollee reimbursed based on R&C** minus $7 copay | Enrollee reimbursed based on R&C** minus $7 copay |
| FRAMES | Once every two consecutive calendar years | Covered frames available at no cost<br>30% discount on non-covered frames | Enrollee reimbursement is $21 | Enrollee reimbursement is $16 minus a $10 copay, if applicable*** |
| LENSES | Once every calendar year | Covered lenses available at no cost | Enrollee reimbursement based on regional fee schedule | Enrollee reimbursed based on R&C** minus $10 copay |
| CONTACT LENSES | Once every calendar year in place of regular lenses | Enrollee pays difference between providers charge and $75 | Enrollee reimbursement is $65 | Enrollee reimbursement is $75 minus $10 copay |

* *Out of Area occurs when there is no network provider within 25 miles of the enrollee's residence.*
** *R&C stands for reasonable and customary charges.*
*** *There is a combined annual copayment of $10 for lenses and frames.*

# General Information About Your Health Care Coverages

## Effect of Medicare

You become eligible for Medicare at age 65, whether or not you choose to continue working. However, if you continue to work after age 65, Social Security will not notify you of your eligibility to enroll for Medicare. **It is your responsibility to contact the local Social Security Administration office to apply for Medicare,** whether or not you are working when you attain age 65. It is suggested this contact be made three months prior to attaining age 65. This will allow sufficient time to process your application so you will not miss your initial opportunity for enrollment.

If you or one of your dependents have a severe long-term disability, end-stage renal disease, or undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fit one of these categories, you should contact your nearest Social Security Administration office to have your case evaluated.

**Generally, you or your dependents will want to enroll for Medicare when you first are eligible to do so.** This is true not only because of penalties which may be incurred in Medicare premiums, but also because Medicare may cover services not covered by the Delphi Program. **Moreover, eligibility for Corporation-paid coverage may depend on Medicare enrollment.** For example, in the event of your death, your surviving spouse will not be eligible for Corporation contributions for any Delphi health care coverages if your spouse is eligible, but is not enrolled, for Medicare Part B at or after age 65.

If you are working, and you (1) are over age 65, or (2) have a dependent who is eligible for Medicare, you may elect to have coverage under both the Delphi Program and Medicare. Generally, if you do so, the Delphi Program will be the primary source of benefits (the first to pay for any covered services). Usually, it is in your interest to apply for Medicare hospital insurance (Part A). No premium is required if you have enough work credits under Social Security, and Part A can supplement the Delphi Program. Enrollment in Medicare medical insurance (Part B) is required for your age 65 or older surviving spouse to receive Corporation-paid coverage in the event of your death (see preceding paragraph), and may provide secondary benefits. For example, Medicare Part B may cover physician office visits, which generally are not covered under the Delphi Program Traditional option.

If you retire and are enrolled in Medicare, Medicare will be the primary source of benefits for you and your dependents who also are enrolled for Medicare. Benefits otherwise payable under the Delphi Program will be adjusted to reflect the amount of benefits payable by Medicare for the same covered services. The Delphi Program will supplement Medicare, to the extent the Delphi Program covers services Medicare does not cover. Your health care claim first must be filed with Medicare. After Medicare pays its portion, the claim should be sent to the appropriate Delphi carrier. In some areas arrangements have been made for Medicare to electronically submit claims to your Delphi carrier, after Medicare has paid its portion. This arrangement is called Medicare crossover and may minimize your involvement in the claims handling process. You should contact your Delphi carrier to determine if Medicare crossover is available in your area.

Most health maintenance organizations (HMOs) do accept Medicare enrollees; however, those plans generally require enrollment in both Part A and Part B, if eligible.

If you are considering joining an HMO as an election under your Medicare coverage, please be careful not to join any HMO that is not listed in your Delphi enrollment materials. To receive the full benefit of both your Delphi and Medicare

coverages, any HMO you join through Medicare must also be offered under the Delphi Program.

If you are enrolled in an HMO, you must follow the guidelines of the HMO regarding Medicare claims processing.

## Special Benefit

**If you are enrolled in Medicare Part B** and are a (1) retiree, (2) surviving spouse receiving a pension benefit, or (3) disabled employee eligible to receive Extended Disability Benefits, you may be eligible to receive a monthly Special Benefit for each month you maintain Medicare Part B enrollment. The amount is equal to the lesser of the Medicare Part B premium or $61.50.

The Special Benefit paid monthly is included in your pension or Extended Disability Benefit check.

Also, under current federal income tax law, because receipt of the Special Benefit is conditioned on your Medicare Part B enrollment as verified by Delphi, the Special Benefit will be non-taxable.

The Special Benefit is not payable to any:

(1) former employee receiving a deferred vested pension benefit, or (2) surviving spouse receiving a survivor benefit resulting from a deferred vested pension benefit.

Not more than one Special Benefit is payable to any individual for any one month.

## Coordination of Benefits

A coordination of benefits (COB) provision is included in all coverages under the Program. **The purpose of this provision is to avoid duplicate payment of benefits in the event an individual is covered by more than one employer's health care plan.** For example, if expenses are incurred by your spouse who is covered by another plan, the other plan may have the primary responsibility of payment. If so, your overall coverages may be enhanced and the cost to the Delphi Program will be reduced.

If COB is done properly, you and your dependents will receive no fewer benefits than you would have received under the Delphi Program alone and you may receive more or enhanced benefits.

### When the Delphi Program is secondary, the following provisions apply:

(1) Certain requirements under the Traditional or PPO options of the Delphi Program, such as predetermination of hospital admissions, are waived. However, if you are enrolled in an ICP HMO option, you are required to obtain services from the HMO panel of providers, or obtain a referral from the HMO in advance, for services to be covered (you should always check with the HMO);

(2) Only those services covered under the Delphi Program will be considered for additional benefit payment. For example, if the primary plan covers office visits, no additional payment will be considered for a Traditional enrollee, because office visits are not covered under the Delphi Traditional option.

NOTE: Enrollees should always choose the maximum level of benefits available under the Primary Plan to enhance benefits available through COB.

**The Delphi carrier should be notified of other plans or programs which may cover you or your dependents.** No notice is required for insurance policies issued in your name, or a dependent's name, for which you pay more than 1/2 the cost. In some cases, you may be required to provide the carriers with additional information.

Once you have identified whether other coverage is involved, you should determine which plan is primary for the individual having a claim. **If another plan or program is primary, the claim should be filed first with the primary plan or carrier.** If the primary plan does not cover the

health care expenses in full, the unpaid balance can be considered under the Delphi Program. You should provide your Delphi carrier with information on the payments made by the other plan or authorize the other carrier to do so. From that point, COB is handled between the carriers. If the remaining balance is for services covered under the Delphi Program, it will pay the balance, up to the maximum permitted.

## Reimbursement of the Delphi Program for Third Party Liability (Subrogation)

If benefits are paid under the Delphi Program, and later it is determined that another party should have been responsible for the expenses, the Delphi Program is entitled to be reimbursed. In that way, financial liability remains where it belongs, with the party responsible incurring the expenses, and Delphi Program costs are reduced.

If you, or one of your covered dependents, is involved in such a situation, **you are required to provide the Delphi carrier with whatever assistance necessary to recover payments made on behalf of the Delphi Program. If you, or your dependent, receive payment for medical expenses, you will be required to reimburse the Delphi Program.**

## The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

**COBRA is a federal law which provides certain employees and dependents the opportunity to continue group health care coverages, on a self-paid basis, when eligibility otherwise would end under the Delphi Program.** Pages 89 and 90 provide additional information.

In some cases, an employee whose eligibility for coverage as an active employee ceases may be eligible for limited continuation under the Delphi Program provisions. In such a case, you, and your eligible dependents, will have a choice between (1) Delphi Program continuation and (2) COBRA continuation. If you are involved in such a situation, you will be advised of both options (Delphi Program and COBRA) at that time.

When health care continuation is discussed in the remaining sections of this booklet, the reference will be to Delphi Program continuation.

## The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 established federal requirements to improve the availability and portability of health care coverage. Employers are required to provide a certificate of prior health care coverage to enrollees who lose coverage.

**An employee or dependent who loses Delphi Program coverage will be automatically mailed a certificate of prior coverage to the employee's address of record.**

This certificate may be used by former enrollees if they become covered under a new health plan which has preexisting condition limitations. The plans that have such limitations are required to reduce the length of time individuals have to wait for coverage to take effect for the preexisting condition by the period of time they were covered under a prior plan.

## Exclusions and Limitations

**Certain health care services and charges are excluded or limited.** A description of general exclusions, and limitations applicable to each benefit provided under the Program may be found in the Program language, or similar documents provided by the Corporation or the carriers.

**In general, programs and/or surgical procedures that are considered to be research, investigational or experimental in nature are not covered services.**

The following are examples of additional excluded services:

- hospital charges — related to domiciliary, custodial, convalescent, nursing home or rest care;
- certain skilled nursing facility charges;
- blood — coverage is not provided for whole blood or packed red blood cells;
- private duty nursing — nursing care which is privately contracted by, or on behalf of, an enrollee with a nurse, or agency, independent of the Program;
- personal convenience items; and
- services provided by family members.

# Cessation of Coverages

Health care coverages cease at the end of the month in which you are last in active service.

Conversion privileges are set forth on page 79.

# How to File a Claim

Your Social Security number always is needed when you communicate with any of the carriers. If you are a dependent, the Social Security number of the employee, retiree, or surviving spouse through whom you have coverage is needed.

## Basic Hospital, Medical and Surgical Claims

**If your carrier is a Blue Cross or Blue Shield plan,** show your health care identification card when you go to the hospital, outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Usually, the hospital or other facility is paid directly by Blue Cross for covered services. Blue Shield generally pays physicians directly for covered services. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, you should submit the charges to your local Blue Cross-Blue Shield plan office.

**If your carrier is United HealthCare,** either you or the provider can submit a completed form for benefit consideration. Standardized claim forms used by, or obtained from, the provider are acceptable. Payment will be made directly to the provider (hospital or outpatient treatment facility, physician, or other provider of covered services), unless you have paid all, or part, of the charges for covered services. In that case, United HealthCare will pay you the appropriate amount.

## DME/P&O

Durable medical equipment (DME) and prosthetic and orthotic (P&O) appliances are subject to National Network arrangements, and network providers are responsible for filing any necessary claims. If you utilize non-network providers you may be required to file a claim. Instructions and forms can be obtained by calling Northwood NPN at 1-800-936-9314.

## Prescription Drug Claims

When you use a network provider, your claims for services will be filed electronically by the provider. If you obtain services from a non-network provider you will be required to pay the full charge and file a claim. Claim forms may be obtained by calling your prescription drug carrier. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. You will be reimbursed the appropriate amount after your copayment has been deducted.

### Mental Health and Substance Abuse Claims

Since the mental health and substance abuse coverages utilize a closed panel of approved providers only, the facility or provider will generally have a supply of claim forms.

Claim forms also may be obtained from (1) the National Benefit Center, or (2) an authorized Central Diagnostic and Referral agency (CDR). If it becomes necessary for you, instead of the facility or provider, to submit a claim form to Connecticut General Life Insurance Company (CG) (e.g., you receive outpatient mental health treatment from a non-panel physician provider to whom you must make payment before you may seek 50% reimbursement for yourself from CG), you are required to send the originals of either (1) approved itemized bills, (2) statements, or (3) receipts for each of the medical expenses for which you are claiming payment.

If you are seeking reimbursement for Substance Abuse services, the substance abuse assessment section of the claim form must be completed by the assessment coordinator from the CDR agency. Otherwise, benefits for that treatment will not be payable.

To be considered, a claim MUST be submitted before the end of the calendar year following the calendar year in which expenses related to the claim were incurred.

### Hearing Aid Claims

Because only approved or participating providers are eligible for reimbursement, such providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the carrier. Benefits are payable only if you obtain hearing aid services from a participating provider, and only if they are obtained in the appropriate sequence. Ask the provider if he or she is participating, before you receive services. If you need the name of a participating provider, inquire at the National Benefit Center, the Blue Cross-Blue Shield Plan in which you are enrolled, or United HealthCare, as may be applicable.

### Dental Claims

Dental claim forms and instructions generally are available from participating dentists in areas where there are employees and retirees. In addition, claim forms also are available from Delta Dental or the National Benefit Center.

### Vision Claims

MetLife is the vision coverage carrier. Network vision providers will have necessary claim forms. In addition, a claim form may be obtained from the carrier, the National Benefit Center, or from a participating provider. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to MetLife. Payment will be made directly to participating providers, unless you have paid all, or part, of the charges for covered services, or you received covered services from a non-participating provider. In that case, MetLife will pay you the appropriate amount.

## Explanation of Certain Terms Applicable to Health Care Coverages

### Approved Facility or Treatment Program...

a facility or a treatment program that has met criteria established by the carrier to provide certain services covered by the Delphi Health Care Program. The following are examples of facilities and treatment programs which must be approved by the applicable carrier for full benefits to be paid:

- hospitals
- skilled nursing facilities
- outpatient mental health facilities

- substance abuse treatment facilities
- outlets for prosthetic or orthotic appliances
- freestanding physical therapy facilities
- home health care programs
- hospice programs
- freestanding ambulatory surgical centers (FASCs)
- hemodialysis programs

In addition, certain services are not payable under the Delphi Health Care Program unless rendered by approved facilities or on approved equipment. Some services also must meet certain medical criteria. The following are examples of services which must be pre-authorized and rendered by approved providers:

- magnetic resonance imaging (MRI)
- extracorporeal shock wave lithotripsy (ESWL)
- positron emission tomography (PET scans)

In addition, Computerized Axial Tomography (CAT) scan services must be rendered on approved equipment.

If you have any doubts about the approved status of a facility or treatment program, you should contact the appropriate health care carrier.

## Carrier...

any entity through which Delphi Health Care Program coverages are administered or benefits are paid, including, but not limited to, Delphi Automotive Systems, a Blue Cross or Blue Shield plan, a commercial insurance company, a health maintenance organization or a preferred provider organization.

## Copayment...

a part of the charge for services which you must pay. Most health care expenses are paid in full by the appropriate carrier. However, you must pay part of the charge, or a "copayment", for certain services, such as outpatient mental health care, prescription drugs, dental care, and vision care.

## Dependents...

certain individuals may be eligible for coverage as a "dependent" of an employee, retiree, or surviving spouse.

**Generally, coverage is limited to your spouse and children.** Effective January 1, 2001, an employee may also enroll an eligible same-sex domestic partner and his/her children. The specifics of dependent eligibility are covered in the Health Care Program document. They are also covered in the "Guide to Dependent Eligibility," available from the National Benefit Center.

In some cases, a dependent may be eligible for Corporation contributions for coverage; while in other cases, a dependent will be eligible only for coverage paid for entirely by you. Surviving spouses cannot add dependents. With the exception of your spouse, your same-sex domestic partner or your child deemed eligible for coverage pursuant to a Qualified Medical Child Support Order, you generally must be able to claim an exemption for the dependent on your federal income tax return (in accordance with Section 151 of the Code). An otherwise eligible child of a divorced employee or retiree is eligible for Delphi contributions for coverage if the divorce decree, or order of the court of proper jurisdiction, stipulates the employee or retiree is legally responsible for providing health care for the child.

**The Corporation's determination of eligibility, in accordance with Delphi Program provisions, is conclusive.** You must provide the Social Security number of all dependents for whom you are required to provide a Social Security number when claiming an exemption on your federal income tax return.

**It is the employee's responsibility to regularly review their dependents to ensure that each one continues to meet all the requirements. Failure to remove a dependent who has become ineligible may result in an overpayment of benefits or premiums which will be collected from the employee.**

### Sponsored Dependents

Certain individuals may be eligible for sponsored dependent coverage. Generally, a sponsored dependent must be related to you. With the exception of a child who is a foreign national and whom you are adopting, sponsored dependents who are not citizens of the United States must, in order to establish eligibility, (1) reside in the United States for one full year, and (2) be legally entitled to remain in this country indefinitely. **You must be able to claim an exemption for each sponsored dependent on your federal income tax return.** You pay the full cost for sponsored dependent coverages. Your sponsored dependents have their health care coverages under the Informed Choice Plan option you elect. **Dental and vision coverages are not available to sponsored dependents.**

If coverages for a sponsored dependent are discontinued voluntarily, because of failure to (1) make a required payment, or (2) continue to meet all the eligibility requirements, a six-month waiting period will be required prior to reinstatement of coverages. Such waiting period will begin upon receipt by the National Benefit Center of an application for reinstatement of an otherwise eligible individual.

### Predetermination...

a system which applies to Traditional option enrollees and requires doctors and/or hospitals to obtain prior approval of all non-emergency, non-maternity hospitalizations and certain other services. Enrollees also may request predetermination. Predetermination of hospital admissions does not apply to Medicare-enrolled individuals where Medicare is primary.

### Provider...

a person (such as a doctor) or a facility (such as a hospital) that provides health care services. Providers are considered to be "participating" when they have signed an agreement with the carrier to accept as "payment in full" the amount which the carrier determines to be an appropriate charge for services rendered. **You should use participating providers, whenever possible to limit the likelihood of personal liability for charges in excess of the carrier's payment.**

If you are uncertain about the participating status, or the need for participation, by any health care provider in your area, contact the appropriate carrier or the National Benefit Center.

### Reasonable and Customary Charge...

an amount determined by the carrier, according to certain standards and considerations or a contracted amount agreed upon as payment in full by the carrier and provider. The carrier's determination is conclusive. The carrier will support your refusal to pay more, unless you have agreed to pay an amount in excess of the reasonable and customary charge.

### Annual Evaluation of Managed Care Options...

The quality and cost performance of HMOs and PPOs is evaluated annually. If the performance of any particular plan is below that of the Traditional option, the Delphi Program calls for monthly contributions by those enrolling in that plan. Other alternatives may be considered, including dropping the plan, freezing enrollments, and making changes to the scope and level of coverages. If such changes occur, they are announced at the time of the annual enrollment.